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ABSTRACT

Youth suicide is recognized as a serious public health problem, but suicide within juvenile facilities has not received comparable attention, and the extent and nature of these deaths remain unknown. This article utilizes an example of a young man in a juvenile justice facility who succeeded in committing suicide to illustrate these points. Information concerning risk factors for suicide and current conditions of confinement in juvenile facilities is provided. The critical components of a suicide prevention policy are discussed. Issues examined within this discussion include: staff training; intake screening and ongoing assessment; communication; housing; supervision; intervention; reporting; and follow-up. Essential for suicide prevention in juvenile justice facilities are collaborative efforts among child-serving agencies. Now is the time to focus additional attention and resources on preventing suicide within these facilities. (Contains 25 references.) (MKA)

Suicide Prevention in Juvenile Facilities

by Lindsay M. Hayes

Nelson, a 16-year-old American Indian, was committed to the Valley Youth Correctional Facility in May 1996 as a disposition for a sexual assault.¹ At an early age he had been physically abused by family members and sexually abused by neighborhood youth. Although he had never attempted suicide, Nelson had an extensive history of suicidal thoughts and tendencies. Psychiatric evaluation led to a diagnosis of conduct disorder and attention deficit hyperactivity disorder. The facility's psychiatrist saw him regularly and prescribed psychotropic medication. In October 1996, Nelson was placed on suicide watch after he had scratched his arms following an altercation with another youth. Nelson told the counselor that he often got depressed and mutilated himself after getting into trouble. Suicide precautions were discontinued several days later.

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In June 1997, Nelson was placed in a quiet room for several hours after he was judged a risk to himself because he had inflicted superficial scratches on his arms and a risk to others because he threatened his peers. He later told unit staff that placement in the quiet room diminished his need to abuse himself (sometimes he would punch the walls to relieve his tension and anger). In July 1997, Nelson was again housed in a quiet room and placed on suicide precautions after threatening suicide. In December 1997, cottage staff referred him to a counselor as they were concerned about his depression and his questioning whether "life was worth living anymore." He was

reportedly upset by the likelihood of being transferred to another facility because of his noncompliance with the treatment program. The situation was exacerbated by his mother's decision to stop visiting him in order to encourage his participation in treatment. The counselor believed that suicide precautions were unnecessary, and Nelson agreed to notify staff should he feel suicidal again.

On January 12, 1998, at approximately 5:30 p.m., Nelson was placed in a quiet room as a discipline for flashing gang signs in the dining room and making sexual comments about female cottage staff. Cottage staff returned Nelson—who appeared quiet and lonely to his peers—to his housing cottage at approximately 6:50 p.m. At approximately 10:30 p.m., cottage staff found Nelson in his room hanging from a

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¹ To ensure confidentiality, the names of the victim and facility have been changed.

ceiling vent by a sheet. Staff initiated cardiopulmonary resuscitation and called for an ambulance. Paramedics arrived shortly thereafter, continued lifesaving measures, and transported the youth to a local hospital where he died a few days later as a result of his injuries.

Prevalence

Nelson's death is one of an undetermined number of suicides that occur each year in public and private juvenile facilities throughout the Nation. According to the Centers for Disease Control and Prevention (CDC), the suicide rate of adolescents ages 15 to 19 has quadrupled from 2.7 suicides per 100,000 in 1950 to 11 suicides per 100,000 in 1994 (Centers for Disease Control and Prevention, 1995). CDC also reported that more teenagers died of suicide during 1994 than of cancer, heart disease, acquired immune deficiency syndrome, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

Several national studies have examined the extent and nature of suicide in jail and prison facilities (Hayes, 1989, 1995), but there has been little comparable national research regarding juvenile suicide in secure detention or confinement. The only national survey of juvenile suicides in secure custody (Flaherty, 1980) reflected a problematic calculation of suicide rates. Reanalysis of suicide rates in that study found that youth suicide in juvenile detention and correctional facilities was more than four times greater than youth suicide in the general population (Memory, 1989). Accurate data on the total scope and rate of juvenile suicide in custody are still lacking.

The U.S. Bureau of the Census has been collecting data on the number of deaths of juveniles in custody since 1989. In the first year of the survey, juvenile officials

self-reported 17 suicides in public detention centers, reception and diagnostic centers, and training schools during 1988 (Krisberg et al., 1991). Fourteen such suicides were reported during 1993 (Austin et al., 1995). Given the epidemiological data regarding adolescent suicide, coupled with the increased risk factors associated with detained and confined youth, the reported number of suicides in custody appears low. The National Center for Health Statistics, however, reported that 30,903 persons committed suicide in the United States in 1996. Of these, approximately 7 percent (2,119) were youth age 19 or younger. For youth younger than age 15, suicides increased 113 percent between 1980 and 1996 (Snyder and Sickmund, 1999). Because of statistics like these, many juvenile justice experts and practitioners believe that suicides are underreported. To date, no comprehensive study of deaths in custody has been undertaken.

Suicide in juvenile detention and correctional facilities was more than four times greater than youth suicide overall.

Risk Factors

Brent (1995) identified mental health disorder and substance abuse as the most important set of risk factors for adolescent suicide. Other risk factors include impulsive aggression, parental depression and substance abuse, family discord and abuse, and poor family support. Life stressors, specifically interpersonal conflict and loss and legal and disciplinary problems, were also associated with suicidal behavior in adolescents, particularly substance abusers. Many of these risk factors are prevalent in youth confined in juvenile facilities (Alessi et al., 1984; Rohde, Seeley, and Mace, 1997).

Although there are insufficient national data regarding the incidence of youth suicide in custody, information suggests a high prevalence of suicidal behavior in juvenile correctional facilities. According to a study funded by the Office of Juvenile Justice and Delinquency Prevention, more than 11,000 juveniles engage in more than 17,000 incidents of suicidal behavior in juvenile facilities each year (Parent et al., 1994). In addition, the limited research on juvenile suicide in custody suggests that confined youth may be more vulnerable to suicidal behavior based on current or prior suicidal ideation (i.e., thoughts and/or ideas of hurting or killing oneself). For example, one study found that incarcerated youth with either major affective disorders or borderline personality disorders had a higher degree of suicidal ideation and more suicide attempts than comparable adolescents in the general population (Alessi et al., 1984).

Policies to provide close observation of suicidal residents did not appear to significantly reduce suicidal behavior.

Other studies found that a high percentage of detained youth reported a history of suicide attempts (Dembo et al., 1990) and psychiatric hospitalization (Waite, 1992) and current and active suicidal behavior (Davis et al., 1991). Two recent studies of youth confined in a juvenile detention facility found that suicidal behavior in males was associated with depression and decreased social connection, while suicidal behavior in females was associated with impulsivity and instability (Mace, Rohde, and Gnau, 1997; Rhode, Seely, and Mace, 1997). Finally, other researchers found high rates of suicidal behavior (Duclos, LeBeau, and Elias, 1994) and psychiatric disorders (Duclos et al., 1998) among

American Indian youth confined in juvenile facilities.

Conditions of Confinement

In August 1994, the Office of Juvenile Justice and Delinquency Prevention published *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (Parent et al., 1994). The study described in that Report investigated several conditions of confinement within juvenile facilities, including suicide prevention practices. Using four specific assessment criteria to evaluate suicide prevention practices—written procedures, intake screening, staff training, and close observation—the study found the following:

- ◆ Only 25 percent of confined juveniles were in facilities that conformed to all four suicide prevention assessment criteria.
- ◆ Facilities that conducted suicide screening at admission and trained staff in suicide prevention had fewer incidents of suicidal behavior among their residents.
- ◆ Suicidal behavior increased for youth housed in isolation.
- ◆ Written policies to provide close observation of suicidal residents did not appear to significantly reduce the rate of suicidal behavior. Because these policies are typically implemented after the risk or attempt is recognized, however, they may reduce the number of suicides.

Critical Components of a Suicide Prevention Policy

The American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCCHC), the National Juvenile Detention Association

(NJDA), and other national organizations have long advocated comprehensive suicide prevention programming. ACA and NCCHC have promulgated national detention and corrections standards that are adaptable to individual juvenile facilities. While the ACA standards are more widely recognized, the NCCHC standards offer more comprehensive guidance regarding suicide prevention and identify the recommended ingredients for a suicide prevention plan: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing (National Commission on Correctional Health Care, 1999). NJDA has developed a suicide prevention curriculum that is incorporated into its detention staff basic training course. Using a combination of ACA and NCCHC standards, the author has developed a comprehensive suicide prevention plan for juvenile facilities that addresses the following key components: staff training, intake screening and ongoing assessment, communication, housing, levels of supervision, intervention, reporting, and followup/mortality review. These components form a continuum of care intended to minimize suicidal behavior within secure juvenile detention and correctional facilities.

Staff Training

The essential component of a successful suicide prevention program is properly trained staff—the backbone of any juvenile facility. Mental health, medical, or other program staff prevent few suicides because juveniles usually attempt suicides in housing units during late evening hours or on weekends, when program staff are absent. Accordingly, suicide attempts must be thwarted by direct-care staff who have been trained in suicide prevention and have developed an intuitive sense about the youth under their care.

All direct-care, medical, and mental health personnel, in addition to any staff who have regular contact with youth, should receive 8 hours of initial suicide-prevention training, followed by 2 hours of refresher training each year. The initial training should address the reasons the environments of juvenile facilities are conducive to suicidal behavior, factors that may predispose youth to suicide, high-risk suicide periods, warning signs and symptoms, components of the facility's suicide prevention policy, and liability issues associated with juvenile suicide. The 2-hour refresher training should review the predisposing risk factors, warning signs and symptoms, and any changes to the facility's suicide prevention plan and discuss any recent suicides or suicide attempts in the facility.

Intake Screening and Ongoing Assessment

Intake screening and ongoing assessment of all confined youth are critical to a juvenile facility's suicide-prevention efforts. Although youth can become suicidal at any point during their confinement, the following periods are considered times of high risk (National Commission on Correctional Health Care, 1999):



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- ◆ During initial admission.
- ◆ On return to the facility from court after adjudication.
- ◆ Following receipt of bad news or after suffering any type of humiliation or rejection.
- ◆ During confinement in isolation or segregation.
- ◆ Following a prolonged stay in the facility.

Suicide prevention begins at the point of arrest.

Intake screening for suicide risk may be included in the medical screening form or on a separate form. The screening process should obtain answers to the following questions:

- ◆ Was the youth considered a medical, mental health, or suicide risk during any previous contact or confinement within this facility?
- ◆ Does the arresting or transporting officer have any information (e.g., from observed behavior, documentation from the sending agency or facility, conversation with a family member or guardian) that indicates the youth should currently be considered a medical, mental health, or suicide risk?
- ◆ Has the youth ever attempted suicide?
- ◆ Has the youth ever considered suicide?
- ◆ Has the youth ever been or is the youth currently being treated for mental health or emotional problems?
- ◆ Has the youth recently experienced a significant loss (e.g., job, relationship, death of a family member or close friend)?
- ◆ Has a family member or close friend ever attempted or committed suicide?

- ◆ Does the youth express helplessness or hopelessness and feel there is nothing to look forward to in the immediate future?
- ◆ Is the youth thinking of hurting or killing himself or herself?

To make a thorough and complete assessment, the intake process should also include procedures for referring youth to mental health or medical personnel. Following the intake process, a procedure should be in place that requires staff to take immediate action in case of an emergency. If staff hear a youth verbalize a desire or intent to commit suicide, observe a youth engaging in self-harm, or otherwise believe a youth is at risk for suicide, they should constantly observe the youth until appropriate medical, mental health, or supervisory assistance can be obtained.

Communication

Certain behavioral signs exhibited by youth may indicate suicidal behavior. Detection and communication of these signs to others can reduce the likelihood of suicide. Direct-care staff who establish trust and rapport with youth, gather pertinent information, and take action can prevent many juvenile suicides (Roush, 1996). There are three paths of communication in preventing juvenile suicides: between the arresting or transporting officer and direct-care staff; between and among facility staff (including direct care, medical, and mental health personnel); and between facility staff and the suicidal youth.

In many ways, suicide prevention begins at the point of arrest. Close observation of what youth say and how they behave during arrest, transport to the facility, and intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time, so arresting officers should pay

particular attention to youth during this time: The anxiety or hopelessness of the situation can provoke suicidal behavior, and onlookers such as family members, guardians, and friends can provide information on any previous suicidal behavior. The arresting or transporting officer should communicate any pertinent information regarding the well-being of the youth to direct-care staff. It is also critical for direct-care staff to maintain open lines of communication with parents or guardians, who often have pertinent information regarding the mental health status of residents.

During intake and screening, effective management of suicidal youth is based on communication between direct-care personnel and other professional staff in the facility. Because youth can become suicidal at any point during confinement, direct-care staff should be alert, share information, and make appropriate referrals to mental health and medical staff. The facility's shift supervisor should ensure that direct-care staff are properly informed of the status of each youth designated for suicide precautions and should similarly brief the incoming shift supervisor. Interdisciplinary team meetings to discuss the status of youth designated for

suicide precautions should occur on a regular basis and include direct-care, medical, and mental health personnel. Finally, the authorization for suicide precautions, any changes in these precautions, and the observations made of youth designated for precautions should be documented on specific forms and distributed to appropriate staff.

Housing

When determining the most appropriate housing location for a suicidal youth, juvenile facility officials often physically isolate and restrain the individual with the concurrence of medical or mental health staff. These responses may prove detrimental to the youth. Isolation increases the sense of alienation and further removes the individual from proper staff supervision (Parent et al., 1994). Housing assignments should maximize staff interaction with the youth and avoid heightening the depersonalizing aspects of confinement. Suicidal youth should be housed in the general population, mental health unit, or medical infirmary, where the youth is close to staff. Removing a youth's clothing (with the exception of belts and shoelaces) and using physical restraints should be done only as a last resort when the youth is physically engaging in self-destructive behavior.

Rooms designated to house suicidal youth should be suicide-resistant, free of significant protrusions, and provide full visibility (including room doors with clear panels large enough to provide staff with unobstructed interior views). Finally, each housing unit in the facility should contain emergency equipment, including a first-aid kit, pocket mask or face shield, Ambubag, and a rescue tool that cuts through fibrous material. Direct-care staff should ensure, on a daily basis, that such equipment is in working order.



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Supervision

Promptness of response to suicide attempts in juvenile facilities is often driven by the level of supervision. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within 4 minutes and death can occur within 5 to 6 minutes (American Heart Association, Emergency Cardiac Care Committee and Subcommittees, 1992). Two levels of supervision are recommended for suicidal youth: close observation and constant observation. Close observation is reserved for youth who are not actively suicidal but express suicidal thoughts (e.g., expressing a wish to die without a specific threat or plan) or have a recent history of self-destructive behavior. Staff should observe such youth at staggered intervals not to exceed 15 minutes. Constant observation is reserved for youth who are actively suicidal—either threatening or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. Some jurisdictions use an intermediate level of supervision with observation at staggered intervals that do not exceed 5 minutes. Other aids (e.g., closed-circuit television and roommates) can be used as a supplement to, but never as a substitute for, these observation levels. Finally, mental health staff should assess and interact with—not just observe—suicidal youth on a daily basis. A careful assessment should be made of the youth's underlying mental health needs, and a plan should be developed to address those needs.

Intervention

The manner and promptness of the staff's intervention after a suicide attempt often determine whether the victim will survive. Providing competent training and establishing an effective system of communication can facilitate this intervention process. First, all staff who come into

contact with youth should be trained in first-aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers a youth engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel, if necessary, and begin first aid or CPR. Third, staff should never presume that the youth is dead; rather, they should initiate and continue appropriate life-saving measures until they are relieved by arriving medical personnel. In addition, medical personnel should ensure daily that equipment used in responding to an emergency within the facility is in working order. Finally, although not all suicide attempts require emergency medical intervention, mental health staff should intervene and assess all suicide attempts.

Reporting

In the event of a suicide attempt or suicide, appropriate officials should be notified through the appropriate chain of command. Following the incident, the victim's family and appropriate outside authorities should be notified immediately. Staff who came into contact with the victim before the incident should submit a statement that details their knowledge of the youth and the incident.

Followup

A juvenile suicide is extremely stressful for staff and residents. Staff may feel ostracized by fellow personnel and administration officials; the direct-care worker may display misplaced guilt, wondering "What if I had made my room check earlier?"; and residents are often traumatized by critical events occurring within a facility. When crises occur, staff and residents should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing

(CISD). A CISD team, comprising professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, firefighters, clergy, and mental health personnel), provides affected staff and residents an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and develop ways of dealing with them (Meehan, 1997; Mitchell and Everly, 1996). For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every suicide and serious suicide attempt (i.e., attempts requiring medical treatment or hospitalization) should be examined through a mortality review process. If resources permit, clinical review of suicide through a psychological autopsy—a retrospective reconstruction of the victim's life—is also recommended (Sanchez, 1999). Ideally, the mortality review should be coordinated by an outside agency to ensure impartiality and should be separate from other formal investigations that may be required to determine the cause of death. The review should include a critical inquiry of the following aspects of the case:

- ◆ Circumstances surrounding the incident.
- ◆ Facility procedures relevant to the incident.
- ◆ All relevant training received by involved staff.
- ◆ Pertinent medical and mental health services and reports involving the victim.
- ◆ Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

Conclusion

"For every two youth (ages 0–19) murdered in 1996, one youth committed suicide" (Snyder and Sickmund, 1999:24). Youth suicide is recognized as a serious public health problem, but suicide within juvenile facilities has not received comparable attention, and the extent and nature of these deaths remain unknown. Collaborative efforts among child-serving agencies and technical assistance training for juvenile facility staff are just two of the components that are essential for suicide prevention within secure juvenile detention and correctional facilities. Now is the time to focus additional attention and resources on preventing suicide within these facilities.

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